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Multidimensional Hope in Counseling and Psychotherapy Scale

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Hope is a foundational facet of psychotherapy and of common factors theories of psychotherapy. Major hope measures developed in psychology are not designed to measure hope as it relates specifically to psychotherapy. There is growing evidence that both content and processes related to hope in this complex domain have unique features. The Multidimensional Hope in Counseling and Psychotherapy Scale (MHCPS) was developed through a multiphase process, including comprehensive literature review, surveys employing overlapping panels of experts, and scale validation with 211 clients in therapy at 7 Canadian locations. The MHCPS includes 34 items across 6 subscales: Future Orientation, Spirituality, Cognitive, Therapeutic Relationship, Other Relationships, and Emotional. The 6 subscales and the full scale possessed high reliabilities and good convergent and divergent validity. Unique aspects of this scale are the inclusion of a spirituality dimension as well as 2 relational dimensions, recognizing that the therapeutic relationship is a common, though not the sole, relational experience of hope for clients in therapy. The MHCPS offers a nuanced and well-validated option for psychotherapeutic research on hope. Among the many assets of the MHCPS is its ability to provide refined information about the complex interrelationship between client hope and client relationships (therapeutic and other). When employed in clinical settings, the MHCPS can be used to identify and open a range of clinical conversations about where and how hope is currently experienced by clients.

Keywords: hope, scale, counseling, psychotherapy, multidimensional

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Hope has been widely considered an essential element leading to client change in counseling and psychotherapy (e.g., Frank & Frank, 1993; Larsen & Stege, 2012; Snyder, 1995). Given that clients arrive in pain and distress, usually feeling very discouraged, isolated, and lacking in confidence, to help them grow in hope is a cornerstone of the process of treatment (Frank & Frank, 1993). Many common factors theories of psychotherapy identify hope as a key aspect of client change (e.g., Asay & Lambert, 1999; Hubble, Duncan, & Miller, 1999). However, hope arguably remains one of the least well-researched areas in counseling and psychotherapy. For example, missing is a multidimensional scale that is relevant and representative of the multidimensional experience of client hope in counseling and psychotherapy (Larsen & Stege, 2012). This article begins by briefly reviewing the history of hope research in psychology and provides a rationale for the Multidimensional Hope in Counseling and Psychotherapy Scale (MHCPS), developed and validated in the present study, to measure hope in counseling and psychotherapy.

Hope in Psychology

Snyder, one of the most prolific and influential hope researchers, defined *hope* as a positive psychological state that emerges from having clear, conscious goals toward which one is striving (Eliott, 2005). To be hopeful requires the development of *pathways thinking*, meaning that the hopeful agent has developed clear, realistic plans of action through which their goals might be attained and the capacity to creatively alter these pathways as needed. To be hopeful also requires *agency thinking*, a confident belief in one's capacity to achieve goals and the belief that one can address whatever barriers might emerge in the pursuit of those goals.

Snyder's cognitive model of hope has been very influential in psychology, so much so that it is generally taken as the standard model of hope. Snyder (1994, 1995) developed a simple and psychometrically sound measure of hope that is widely used, acting to promulgate the underlying model. However, the model and scale have been critically examined. The focus of the model and scale is on mobilizing the required cognitive resources to plan and achieve goals. The model and scale fail to address other important aspects of hope such as emotional, relational, and spiritual elements (Larsen & Stege, 2012; Schrank, Woppmann, Sibitz, & Lauber, 2011; te Riele, 2010). Further, others (e.g., Juntunen & Wettersten, 2006; Robinson & Rose, 2010) contend that hope must be studied as a distinctive phenomenon within different domains.

Scioli, Ricci, Nyugen, and Scioli (2011) recently generated a multidimensional model of hope. They viewed hope as "a future-directed, four-channel emotion network, constructed from biological, psychological, and social resources" (p. 79). The first three channels are survival, mastery, and attachment, which ground hope in core features of the biological and psychological makeup of human beings, suggesting that its roots are in early development (e.g., *mastery*, i.e., striving for competence and autonomy, and *attachment*, i.e., striving for relationship and intimacy). The fourth channel, spiritual beliefs, is interpreted broadly and inclusively.

Based on their theory, Scioli and colleagues (2011) developed items for two integrated hope scales, one focusing on trait hope and the other on state hope. The trait items were administered to a group recruited through a newspaper advertisement and a group of college students. The state items were administered to a group recruited through the Internet. Exploratory factor analysis followed by confirmatory factor analysis was used to determine the number of factors for each scale. The Trait scale had six factors, and the State scale had four factors. Reliability and validity of the number of factors for each scale were assessed. Although the reliability of the factors was good, the State scale (mastery, attachment, survival, and spirituality) more cleanly supported the hypothesized model than the Trait scale. Though the two scales are multidimensional, they do not have any obvious connection to the demands, processes, and subtleties of psychotherapy.

The Role of Hope in Counseling and Psychotherapy

Hope is a central and a necessary feature of effective counseling and psychotherapy. Frank (1961) and Frank and Frank (1993) argued that types of psychotherapy are socially constructed with four common elements: an emotionally

charged relationship with a helper, a setting, an underlying rationale or myth for the therapy, and a ritual. One of the key points emphasized by Frank (1961) was that people arrive at psychotherapy profoundly demoralized and discouraged, so hope must be inculcated early if a successful treatment is to proceed. These pioneering insights were a crucial building block in an approach to psychotherapy called the common factors model (Wampold & Imel, 2015). A common factors approach emphasizes that several aspects of therapy, which are found in all effective therapies, are central to psychotherapeutic change. Instilling hope is one of the most crucial of these common factors.

Asay and Lambert (1999) integrated all the quantitative support for a common factors perspective and clustered the evidence into a four-factor model for explaining change. The four factors and their estimated percentage contribution to change were client factors and extratherapeutic events (40%), relationship factors (30%), expectancy and placebo effects (15%), and technique/model factors (15%). Following Frank (1961), Asay and Lambert interpreted the expectancy effect to be about the patient's hope that they will be helped. Similarly, Snyder, Michael, and Cheavens (1999) asserted that hope is a unifying framework in therapy and that the effects of placebo are the result of hope. Swift and Greenberg (2015) offer an excellent summary of the substantial research literature related to the placebo effect in medicine and psychotherapy, which is probably the strongest empirical evidence for the importance of hope in the process of healing and change. Hope as a central unifying factor in psychotherapy has been supported by a number of other research studies. These include, for example, Cutcliffe's (2004) research on the complex process of constructing hope in therapy for the bereaved; Egeli, Brar, Larsen, and Yohani's (2014) research on the duality of hope and vulnerability in therapy with couples; and, in a study of a positive psychology group intervention for people with psychosis, a change in crude hope scores from baseline differentiated the treatment and control groups (Schrank et al., 2016). Further, research on formative processes in therapy and on building the working alliance indicates that hope plays an especially central role in early therapy sessions (within 3 to 4 weeks of beginning treatment; Horvath & Greenberg, 1994; Ilardi & Craighead, 1994; Wickramasekera, 1985; Wilkins, 1979, 1985).

Measuring Hope in Counseling and Psychotherapy

Recent studies on hope in counseling and psychotherapy (e.g., Iaboni & Larsen, 2019; Larsen, Stege, Edey, & Ewasiw, 2014; Schrank et al., 2011) have demonstrated growing evidence that the content and process of hope in counseling has unique features. Similarly, in fields such as education researchers have seen fit to construct more nuanced, context-specific hope scales (e.g., Robinson & Rose, 2010). Two research teams have attempted to create scales for the measurement of hope in a psychotherapy context.

Bartholomew, Scheel, and Cole (2015) adopted Snyder's (1995) theory of hope and accepted the assumption that hope is an essential feature of effective therapy and developed the Hope for Change through Counseling Scale (HCCS) that was designed to "assess hope for change in the process of counseling" (p. 694). They developed a pool of 55 items for each of Snyder's goals, pathways thinking, and agency factors and conducted three sequential studies. First, 191 psychology students were presented clinical vignettes of students suffering from loneliness or procrastination. The second study used Amazon Mechanical Turk. Participants (n = 231) were primarily Asian, and previous counseling experience was reported by 143 participants. The third study was designed to validate the HCCS with 50 university students who were receiving individual therapy. Several problems arise from the procedures used to create this scale. The uncritical adoption of Snyder's model, and the purely rational derivation of the items in the scale from the components of that model, foreclosed the possibility of considering other potential dimensions to hope and eliminated the empirical generation of new items. Two of the three stages of scale creation involved using imaginative exercises to test the scale with undergraduate students and others not currently in therapy, clearly diminishing the validity of those procedures.

Ward and Wampler (2010) developed a theory of hope aligned with Snyder's theory of hope in that it is focused on the client's desired outcome, with two important distinctions: (1) it

includes a specific focus on relationship, and (2) it does not assume that all feelings are the result of cognitive appraisal. Based on this theory, Ward, Griswold, Johnson, and Grahe (2017) developed Ward's Hope Scale, a 20-item hope scale for use in counseling. In Study 1, for validation purposes, the Ward Hope Scale, Snyder State Hope Scale (Snyder et al., 1996), Herth Hope Index (Herth, 1992), Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988), and General Self-Efficacy Scale (Schwarzer & Jerusalem, 1995) were used. Psychology students were recruited from an introductory statistics/methods research course and were asked to randomly recruit 100 Facebook friends, which resulted in a final sample size of 206 participants who completed all the measures.

Convergent validity with each of the Ward Hope Scale, Snyder State Hope Scale, Herth Hope Index, Multidimensional Scale of Perceived Social Support, and General Self-Efficacy Scale measures was mixed for both five- and four-factor solutions. The 20-item form was then revised. In Study 2, the measures used were the revised 20-item Ward Hope Scale, Herth Hope Index, and Snyder State Hope Scale. Participants from Study 2 were recruited via the same method as Study 1, yielding 225 completed initial surveys. The confirmatory factor analysis showed that the four subscales were well defined. The internal consistency and test–retest reliability were good, whereas the evidence of convergence and divergence was again mixed. The strength of this scale is that the creators began with an assumption that hope contains emotional and relational elements as well as cognitive and goal-oriented elements. But it suffers even more strongly than the Bartholomew et al. (2015) scale did from a testing procedure that failed to include participants who are currently engaged in therapy. If hope has a specific contextual meaning for those engaged in psychotherapy, then a scale designed to measure such hope must be created in a way that engages directly with that context.

Purpose of the Study

Given the limitations stated in the previous two sections, there is no well-designed scale to measure hope in counseling and psychotherapy. Snyder's (1995) model and scale are cognitively focused and address goals while lacking other aspects of hope such as emotional, relational, and spiritual elements. The two scales created by Scioli and colleagues (2011) do not have any obvious connection to the demands, processes, and subtleties of psychotherapy and they used nonclient samples. Likewise, Bartholomew et al. (2015) and Ward et al. (2017) used largely nonclient samples in the creation of their scales. Further, Bartholomew and colleagues adopted Snyder's hope theory with its factors of agency, pathways thinking, and goals. Ward et al. demonstrated somewhat mixed validity results. Given the importance of hope in counseling and psychotherapy, the purpose of the present study was to develop a reliable and valid multidimensional scale to measure hope in that context. The process avoided beginning with any a priori assumptions about the nature of hope in the process of counseling. We built the construct of hope empirically from a review of existing research on hope in therapy and the experiences of a broad range of experts, and we tested and refined the scale with clients engaged in psychotherapy.

Method and Results

Given the sequential nature of the development of the MHCPS, the methods and results are presented together for each of the four phases conducted. Phase 1 includes the development and validation of the definitions of hope and each of the initial eight dimensions. Phase 2 involves the development and validation of the items for each of nine dimensions, where the ninth dimension was recommended by the panel of experts in Phase 1. Phase 3 involves collecting responses from clients currently in counseling and psychotherapy and an exploratory factor analysis of the responses to determine empirically whether the nine dimensions would remain. Phase 4 examines the convergence and divergence evidence of the six dimensions of the MHCPS derived in Phase 3.

Phases 1 and 2 were approved by the University of Alberta Research Ethics Board 2 (REB 2). Phase 3 of this study was approved by University of Alberta REB 2, MacEwan University REB, University of New Brunswick REB, and McGill University REB.

Phase 1—Development of Definitions of Hope and the Dimensions of Hope

Clark and Watson (1995) stated the "critical first step [in scale development] is to develop a precise and detailed conception of the target construct and its theoretical context" (p. 310). Redlich-Amirav, Larsen, and Armijo-Olivo (2016) conducted a review of the various hope scales and found the measures lacked contextual specificity, a finding echoed in Iaboni and Larsen's (2019) systematic review on hope in qualitative counseling and psychotherapy research. Consequently, the present study began with an extensive review of cross-disciplinary research to examine individuals' experience of hope in therapy.

Using the search terms *hope* or *hoping* AND *counseling* or *psychotherapy* over 7,000 articles, book chapters, and dissertations were identified in the CINAHL, PsycINFO, and Medline databases. Materials were removed that (1) were about nonpsychotherapeutically related counseling (e.g., genetic counseling or health counseling), (2) used hope as a folk term (e.g., "Hope for a Cure"), (3) did not provide an explicit definition of hope, (4) were conducted on nonadult populations (i.e., children or adolescents), and (5) discussed hope-based therapeutic interventions. Twenty-nine articles remained, which were from counseling, psychotherapy, counseling psychology, marriage and family therapy, social work, and nursing, thus representing an interdisciplinary perspective on hope in counseling and psychotherapy.

Based on a comprehensive review of the 29 articles, constitutive definitions of hope and the eight dimensions of hope appropriate for use with counseling and psychotherapy clients were created by two members of the research team. The eight dimensions included the following: therapeutic relationship, other relationships, cognitive, emotional, temporal, behavioral, process, and personal meaning.

Review of definitions. A panel of 20 psychologists with specialized knowledge of hope research was approached online to provide feedback on the initial definitions of hope and each of the eight dimensions in counseling and psychotherapy. Each member was sent a review form on which the definitions were provided and five questions. They were asked if the definition of hope and each dimension was (1) correct (yes/no), (2) clear (yes/no), and (3) if each dimension definition was needed (yes/no). Space was provided for comments, and the reviewers were asked to suggest additional dimensions that were needed.

Panel members. Of the 20 invited panel members, 14 (70.0%) responded providing feedback and suggestions specific to the definition of hope and each dimension in counseling and psychotherapy. The panel members included 12 doctoral level and two masters-level licensed psychologists, 11 of the 14 panelists were females and three were males, and the panelists ranged in age from the mid-20s to the mid-60s. Thirteen panel members were from Canada and one was from South Africa. Though panelists were invited from the United States and Australia, they did not choose to participate. The participating panel members reflect a global western/northern perspective on hope, consistent with the preponderance of current research on hope in psychotherapy and counseling. Twelve of the panelists had a University affiliation (i.e., faculty member, adjunct appointment, postdoctoral fellow, or were clinicians in a student counseling center). The two remaining panelists worked at a community service clinic and in independent practice. All had conducted hope research either as university researchers or as doctoral students.

Results. One panel member provided comments and suggestions but did not answer the five questions. The remaining 13 panel members provided comments and suggestions and answered the questions, but often not all the questions. For example, for therapeutic relationship, nine of the 10 panel members felt the definition was correct, nine of 13 felt the definition was clear, and 13 of 13 indicated that therapeutic relationship was needed.

The panel members indicated that the definition of hope was not correct and clear. They indicated that the definition for emotional was not as correct as the definitions for the other seven dimensions and that the definitions of emotional and temporal were not as clear as the definitions of the remaining dimensions. Last, the panel members indicated that the eight dimensions were needed for the client population and that a ninth dimension, Spirituality, was needed. Based on the panel members' suggestions, the definitions were revised. The revised definitions of hope and each of the nine dimensions are provided in Table 1.

Table 1
Definitions of Hope and the Nine Dimensions

Hope
Client hope in psychotherapy is the client's anticipation of meaningful change in the face of uncertainty. Client hope in psychotherapy is experienced in one or more of the following dimensions: relational (therapeutic and other), cognitive, emotional, temporal, behavioral, process, personal meaning, and spirituality.
Dimension 1: Therapeutic Relationship
A safe, trusting, and understanding relationship with the therapist.
Dimension 2: Other relationships
Supportive as well as problematic relationships with others are discussed with the therapist.
Dimension 3: Cognitive
Shifts in perspective, growing awareness of possibilities, development of goals, and planning strategies to meet them.
Dimension 4: Emotional
Affective and embodied experience of hope.
Dimension 5: Temporal
References the past, is oriented to the future, and is experienced within the present, shifting fluidly across time perspectives.
Dimension 6: Behavioral
Becoming mobilized, purposely doing something different, or taking action toward a specific goal or goals.
Dimension 7: Process
Awareness that change is occurring, and acceptance that change and hope fluctuate.
Dimension 8: Personal Meaning
Growing awareness and assertion of identity, values, and purpose.
Dimension 9: Spirituality
Belief in a higher power, a sense of transcendence, unity, or connection beyond oneself.

Phase 2—Item Development

Initial item development occurred concurrently with the development of the definitions for hope and each of the initial dimensions to ensure that the items referenced to one dimension did not inadvertently measure more than one dimension (Devellis, 2012). Further item refinement and additional item development occurred following the review of definitions by the expert panel and using the revised definitions in Table 1. The initial pool of items contained 200 items. The items were then assessed by the research team for clarity, content relevance, and to ensure content representativeness (Messick, 1989). This assessment resulted in 138 items distributed across the nine dimensions.

Review of items. A panel of 30 psychotherapists with specialized knowledge in hope (20 from the initial review panel plus an additional 10) were approached online to provide feedback about the items for each dimension. Each panel member was sent a review form that contained the revised definitions and the items referenced to each dimension. First, they were asked to carefully read the definitions of hope and each dimension. Then they were asked to rate the relevance of each item for the dimension to which it was referenced using a five-point Likert scale on which 1 = *does not fit at all* and 5 = *excellent fit*. They were asked to indicate a different dimension for an item they rated as 1; if there was no other dimension, they entered 0. The panel members were asked how well the items they rated as 4 or 5 represented the dimension using a three-point rating scale (*reasonably well*, *well*, *very well*). Last, for each dimension they were asked to change the wording of an item where needed, add a comment about an item, or propose one or more new items.

Panel members. Of the 30 invited panel members, 21 (70.0%) provided feedback about item relevance and content representativeness, offered suggestions for revising existing items, and/or proposed new items. Of the 21 panel members who responded, 13 were from the panel that reviewed the initial definitions. Fifteen of the 21 panelists were female and six were male, and panelists ranged in age from the mid-20s to the mid-60s. Sixteen respondents were from Canada, two were from Australia, and one each from South Africa, Sweden, and the United States. Whereas 19 panel members had a doctoral degree and two members had a master's degree, all 21 panel members were licensed psychologists. Fourteen panel members had a university affiliation (i.e., faculty member, adjunct appointment, postdoctoral fellow, or a clinician in student counseling centers). The remaining panelists worked in community service agencies, hospitals, and community clinics.

Results. The item means and item medians were between 4 and 5, except for spirituality, which were slightly less than 4. The ranges of the item difficulties were between 2 to 5. For each item, no more than four panel members gave lower ratings. Thus, the panel members as a group deemed the items to be relevant to the dimension to which they were referenced. They consistently agreed that therapeutic relationship, cognitive, emotional, temporal, behavioral, process, and personal meaning dimensions had items that represented that domain well or very well. Half of the panel members felt that items for other relationships and spirituality represented dimensions reasonably well or well. The members of the research team considered what the panel members had indicated and deleted 21 items. The 21 items were deleted because they had a median of two, were redundant with other items in the scale, or they were ambiguous.

Of the remaining 117 items, 34 items were reversed coded to prevent a respondent from simply responding to each item in the same way (DeVellis, 2003; Fink, 2003). The items were placed in a randomized order in the field test form.

Phase 3—Factor Analysis to Empirically Determine Dimensionality

Sample. The instruments were administered online (SurveyMonkey) to clients receiving psychotherapeutic services at seven counseling sites. Five sites were in Alberta, one site was in Québec, and one site was in New Brunswick. The seven sites included four sites offering services to university students, a community mental health clinic, a rehabilitation center, and a sexual assault center.

The primary investigator (Denise J. Larsen) and/or project coordinator (Jesse McElheran) conducted a workshop on hope in psychotherapy to introduce the project to staff at the five sites in Alberta and the site in New Brunswick. The site collaborator in Québec, a specialist in hope and therapy herself, introduced the project during staff meetings at that site. At five sites participants were introduced to the research project and invited to participate by their therapists. At one site, the project was introduced to the participants by their individual therapists, but participants were invited to take part in the study by the site administration team. At the seventh site, clients were sent an e-mail with a link directing them to the survey.

The clients at all seven sites were invited to participate at some point after the third therapy session and before the sixth therapy session. Clients who participated indicated consent by completing the online survey, as detailed in the consent form provided with the survey form. Therefore, it is not possible to determine the actual number of clients at each site given the constraints of client confidentiality. Completion rates for those who began the online survey ranged between 86% to 94% across six of seven sites and was 63% at the seventh site.

Participants. A total of 245 clients responded over a period of 2.5 years. Of the 245 clients, 34 did not complete all the scales and/or failed to respond to half of the items in each scale. The percentage of respondents by site in the final sample varied from 2.8% to 39.8%. Reasons for the variation included the size of the agency, the length of time the data were collected in each agency, and a change in personnel at one agency.

Of the 211 participants, 75.8% were women, 20.4% were men, 0.5% were transgender, 1.9% indicated other, and 1.4% did not identify their gender. The ages ranged from 17 to 60 years, with two thirds less than 31 years. Approximately three quarters (74.2%) were of Canadian or European origin. The remainder were, in order of frequency, East or South East origin, multiethnic/mixed race, and North American

Aboriginal. (Canada is a multi-ethnic country. Ethnic descriptors are the same as those employed in the national census, a common research practice in Canada.) Just over three in five participants (62.6%) were single, 17.5% were married, 8.1% were common law, 3.8% were separated, 6.2% were divorced, and 1.0% were widowed. With respect to the highest level of education each client possessed, 2.4% did not complete high school; 21.8% completed high school; 32.7% had some postsecondary or trade education; 10.9% completed a diploma or trade program; and 23.7%, 7.1%, and 0.9%, respectively, completed a bachelor, master's, and doctoral program.

Approximately two thirds (64.5%) of the clients had previously attended therapy. The clients were asked to check the reason or reasons for attending their current therapy sessions. The three most frequent reasons were anxiety (65.9%), depression (61.1%), and stress (52.1%). Relational issues (37.0%) and family contact (24.6%) were the next most common reasons. The last three more common reasons were grief or loss (14.7%), sexual abuse or assault (12.3%) and sexuality (4.3%).

Analysis. First, the reverse coded items were recoded so that all 117 items had the same polarity. Second, the mean of each item was substituted for the missing responses to that item (Dodeen, 2003; Downey & King, 1998). Third, exploratory factor analysis was used since this was the first statistical analysis to look at dimensionality among these items. However, the ratio of the number of clients who responded divided by the number of items was insufficient to allow analysis of all 117 items at one time. Therefore, an iterative procedure involving principal axis extraction followed by direct oblimin transformation with $\delta = 0$ was employed (Gorsuch, 1983). The iterative procedure continued until the closest simple pattern matrix was achieved.

For example, the first iteration involved an analysis of the therapeutic relationship and other relationships subscales. Two correlated factors with simple structure were found, with one factor for therapeutic relationship and the other for other relationships. Next, spirituality was added. Three correlated factors with simple structure were found—therapeutic relationship, other relationships, and spirituality. The temporal, behavior, and process items were then analyzed. The solution was complex. At this point, items with pattern coefficients less than |0.30|. were removed followed by items with a complexity greater than one. This resulted in one factor that contained temporal, behavioral, and process items that dealt with the future. The cognitive and emotional items were then added to the one factor solution. Three factors were found, but many had complexity greater than one. Again, items with pattern coefficients less than |0.30| were removed followed by the items with complexity greater than one. The items from the two three factor solutions were then combined. Six interpretable factors were derived. The items for personal meaning were then added, which led to an uninterpretable solution, with many of the personal meaning items having coefficients less than |0.30|.

The pattern matrix of the final solution is provided in Table 2. The six factors are future orientation, spirituality, cognitive, therapeutic relationship, other relationships, and emotional. Except for future orientation, the remaining five subscales correspond to the subscales initially postulated. Future orientation comprises items from the initial Temporal, Behavior, and Process subscales that dealt with the client's future. No items from personal meaning are part of the final solution.

The mean, standard deviation, and internal consistency of the six subscales and the total scale are provided in Table 3 together with the measures used to determine convergent and discriminant validity. Examination of the frequency distributions of each subscale revealed that the clients' responses tended to cluster around the mean score. Given the mean for spirituality is close to the midpoint of the scale, whereas the other means are above the midpoint, there was greater variability for Spirituality than for the other five subscales. The internal consistencies of the subscales (0.78 for Other Relationships; from 0.88 to 0.93 for the five remaining scales) and the total scale (0.94) are high. The lower value for Other Relationships is attributable to the lower number of items (4 vs. 6 for each of the remaining subscales).

The correlations among Future Orientation, Cognitive, Therapeutic Relationship, Other Relationships, and Emotional are moderate to moderately strong in value. The correlations

Table 2
Pattern Coefficients

Item	Future orientation (FO)	Spirituality (S)	Cognitive (C)	Therapeutic relationship (TR)	Other relationships (OR)	Emotional (E)
				FO		
I hold on to the idea that my future can be better.	0.634					
I trust that things can get better even where they are hard.	0.615					
I am willing to take the next step.	0.503					
I trust that things are getting better even when I have difficulties.	0.460					
Therapy is helping me imagine the future.	0.453					
I have moments when I feel hopeful.	0.316					
				S		
Being in touch with my spiritual beliefs in therapy gives me hope.		0.898				
My spiritual beliefs do not give me hope.		0.709				
Therapy reminds me of my spiritual beliefs.		0.840				
My spiritual beliefs inspire me.		0.771				
In therapy, I do not feel close to a higher power.		0.735				
Therapy feels spiritual to me.		0.680				
				C		
I am not capable of making good changes in my life.			0.763			
I do not believe I can change.			0.669			
I cannot see new possibilities.			0.514			
I believe that I can reach my goals.			0.453			
Remembering times when I overcame difficulties helps me see a brighter future.			0.401			
I can see new ways to use my strengths.			0.334			
				TR		
I trust my therapist.				0.903		
I feel safe with my therapist.				0.881		
My therapist believes in me.				0.808		
My therapist supports me.				0.797		
My therapist understands my challenges and difficulties.				0.751		
I can tell my therapist has hope for me.				0.732		
				OR		
Therapy reminds me of other people in my life who want the best for me.					0.797	
Therapy does not remind me of people who support me.					0.492	
I am approaching family in a healthier way.					0.359	
There are people in my life who will help me.					0.346	
				E		
Sometimes I feel emotionally lifted during therapy.						0.730
My therapist is competent.						0.697
I sometimes leave therapy feeling inspired.						0.675
Sometimes I feel like a weight has been lifted off my shoulders.						0.572
Sometimes during therapy, I feel more hopeful.						0.476
Sometimes I feel hopeful in the moment.						0.414

Table 3
Means, Standard Deviations, Internal Consistency, and Correlations for Hope Scales and Validity Scales

Variable	FO (No. of items = 6)	S (No. of items = 6)	C (No. of items = 6)	TR (No. of items = 6)	OR (No. of items = 4)	E (No. of items = 6)	TS (No. of items = 34)	Optimism (No. of items = 6)	Depression (No. of items = 7)	Anxiety (No. of items = 7)	Stress (No. of items = 7)	Hope (No. of items = 8)
	M (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)
	24.04 (3.37)	17.26 (5.45)	23.60 (3.90)	25.42 (3.66)	15.50 (2.54)	24.60 (3.79)	19.66 (14.05)	16.56 (3.97)	7.98 (4.63)	6.09 (4.60)	9.54 (4.28)	25.49 (7.34)
	Internal consistency											
	0.88	0.89	0.88	0.93	0.78	0.89	0.94	0.57	0.87	0.83	0.81	0.87
FO	—	0.34	0.76	0.60	0.67	0.66	0.85	0.35	−0.28	−0.24	−0.23	0.60
S		—	0.35	0.14	0.30	0.26	0.58	0.32	−0.28	−0.04	−0.13	0.31
C			—	0.50	0.66	0.58	0.81	0.36	−0.45	−0.31	−0.28	0.69
TR				—	0.54	0.72	0.72	0.21	−0.21	−0.22	−0.26	0.28
OR					—	0.57	0.77	0.28	−0.36	−0.17	−0.18	0.52
E						—	0.80	0.29	−0.19	−0.20	−0.16	0.38
TS							—	0.40	−0.38	−0.23	−0.25	0.61

Note. FO = Future Orientation; S = Spirituality; C = Cognitive; TR = Therapeutic Relationship; OR = Other Relationship; E = Emotional; TS = total scale.

among these five subscales with Spirituality are weaker.

The Multidimensional Hope in Counseling and Psychotherapy Scale. Based on analyses, the resulting MHCPS is a 34-item scale with a five-point Likert response (1 = *strongly disagree* to 5 = *strongly agree*; see Table 2 for items). Hope in the MHCPS is defined as the client's anticipation of meaningful change in the face of uncertainty. The six subscales are Future Orientation, Cognitive, Therapeutic Relationship, Other Relationships, Emotional, and Spiritual. The scale is explicitly designed for use in counseling and psychotherapy. Instructions at the outset of the scale direct respondents to "Please read each statement and click the box which indicates how much this statement **applies to your current experience of hope in therapy**" (boldface type appeared in the original).

Phase 4—Validation

Instruments.

Revised Life Orientation Test (LOT-R). The LOT-R (Scheier, Carver, & Bridges, 1994) measures a respondent's level of optimism. The test includes three optimism statements (Items 1, 4, and 10), three pessimism statements (Items 3, 7, and 9), and four distractor statements (Items 2, 5, 6, and 8). Respondents answer the statements by indicating their level of agreement on a fully labeled five-point Likert scale (*strongly agree*, *disagree*, *neutral*, *agree*, *strongly agree*). The four distractor items are not included as part of the score. The polarity of the three pessimism items are reversed prior to scoring so that values close to five on three optimism and three pessimism items contribute to a score that indicates a high degree of optimism. Scheier and colleagues reported that Cronbach's alpha was 0.78 and that the test–retest reliabilities ranged from 0.68 to 0.79 for intervals of 4 to 28 months.

Depression Anxiety Stress Scales (DASS21). The DASS21 is a set of three self-report scales designed to measure the negative emotional states of depression, anxiety, and stress (Lovibond & Lovibond, 1995). The initial form of the DASS contained 42 items. The DASS21 was developed to reduce the response time. Respondents answer the statements by indicating their level of agreement on a fully labeled four-point

Likert scale (*never applied to me*, *sometimes applied to me to some degree*, *often applied to me to a considerable degree or a good part of time*, *almost always applied to me very much or most of the time*). Scores for depression, anxiety, and stress are calculated by summing the scores for the relevant items for both the long and short forms.

Lovibond and Lovibond (1995) reported Cronbach's alphas of 0.88 for depression, 0.82 for anxiety, and 0.90 for stress for nonclinical samples for the DASS21. Antony, Beiling, Cox, Enns, and Swinson (1998) used the DASS21 and found Cronbach's alphas of 0.94 for depression, 0.87 for anxiety, and 0.91 for stress for a sample comprised respondents with agoraphobia ($n = 67$), obsessive–compulsive disorder ($n = 74$), social phobia ($n = 17$), specific phobia ($n = 46$), major depressive disorder ($n = 46$), and no disorder ($n = 49$).

Adult Hope Scale (AHS). The AHS (Snyder et al., 1991) is a scale that measures a respondent's level of hope. The scale includes four items that measure agency, four items that measure pathways, and four distractor items. Respondents answer the statements by indicating their level of agreement on a fully labeled eight-point Likert scale (i.e., definitely false, mostly false, somewhat false, slightly false, slightly true, somewhat true, mostly true, definitely true). The four distractor items are not scored. Scores can be computed at the subscale level or combined to form a score for total hope.

Snyder and colleagues (1991) reported Cronbach's alphas of 0.74 to 0.84 for overall hope, 0.71 to 0.76 for the Agency subscale, and 0.63 to 0.80 for Pathways subscale when sampling student and clinical populations. They also reported test–retest reliabilities for the overall hope of 0.80 or greater for time periods up to 10 weeks for the student population. It was hypothesized that optimism measured by the LOT-R and hope measured by the AHS would correlate moderately to strongly positive with the MHCPS and that depression, anxiety, and stress as measured by the DASS21 would correlate low to moderately negative with the MHCPS.

Participants. The LOT-R, DASS21, and AHS were administered to the same respondents who responded to the MHCPS. The respondents responded at one time to all four instruments. The MHCPS was administered first, followed in turn by the LOT-R, DASS21, and AHS.

Analysis and results. The polarity of the negatively worded items was reversed so that a high score reflected higher amount of optimism, depression, anxiety, stress, and hope. The value of Cronbach's alpha (.57) for optimism in the present study (see Table 3) is somewhat less than the value reported by Scheier and colleagues (1994). For the DASS21, although Cronbach's alphas were comparable to the values reported by Lovibond and Lovibond (1995) for depression (0.87 vs. 0.88) and anxiety (0.83 vs. 0.82), the value for stress was somewhat less (0.81 vs. 0.91). The value of Cronbach's alpha for the AHS was slightly larger than the upper value of the range reported by Snyder and colleagues (1991).

Although the correlations among each of the six MHCPS subscale scores and the total MHCPS score and optimism scores were as expected, positive, they were not as high as expected. The correlations ranged from 0.21 to 0.45. One reason for this is the low Cronbach's alpha for optimism that would attenuate the correlations. The correlations between each of the six MHCPS subscale scores and the total MHCPS score and the depression, anxiety, and stress scores were as expected, negative. These correlations ranged from −0.04 to −0.45. Last, the correlations between the MHCPS scores and AHS score were as expected, positive, and generally greater than the correlations with the optimism scores. The latter correlations ranged from 0.28 to 0.69. Taken together, the correlations suggested weak convergence evidence with optimism and stronger convergence evidence with Snyder's (1995) hope, and strong divergence evidence with depression, anxiety, and stress.

Discussion

The MHCPS fills the need for a well-validated, context-sensitive measure that recognizes the multidimensional complexity of client hope in counseling and psychotherapy. With a total of 34 items, the MHCPS has six subscales: Future Orientation (six items), Spirituality (six items), Cognitive (six items), Therapeutic Relationship (six items), Other Relationships (four items), and Emotion (six items). The scale is ultimately intended for use both in research and

as a clinical instrument in counseling and psychotherapy.

Development of the MHCPS directly responds to the call by Larsen and Stege (2010a) for "deeper reflection on the common factors model and the boundaries between the common factors" (p. 287), most notably the questionable boundary between hope and the therapeutic relationship articulated in many common factors models. Larsen and Stege (2010a, 2012) found that for both therapists and clients, the experience of hope in session is deeply entwined with the therapeutic relationship. Psychotherapy integration theorists make similar assertions: Greenberg (2004) suggested that the therapeutic relationship supports the client to "feel more secure and confident about trying new solutions to old problems" (p. 236), whereas Frank and Frank (1993) maintained that it was through the emotionally charged therapeutic relationship that the client comes to accept the therapist's belief that positive change is possible. Psychotherapy researchers concur. For example, O'Hara and O'Hara (2012) found that the therapist's belief in the client, expressed through the relationship, was a central component in fostering hope, whereas Cutcliffe (2004) found hope to be inextricably linked with the therapeutic relationship through deep human connection. The MHCPS is a research-based measure that reflects the multidimensional complexity of hope and the complex relationship between hope and therapeutic bond. An additional distinctive feature of the MHCPS is its sensitivity to the therapeutic context when compared to global hope scales such as the Comprehensive Hope Scale (Scioli et al., 2011). A MHCPS score on the subscale Therapeutic Relationship specifically reflects client hope as experienced within the counseling and psychotherapy relationship, whereas the Other Relationships subscale of the MHCPS reflects how addressing a client's relationships with others during therapy contributes to her/his experience of hope in the session.

Spirituality was not an anticipated dimension of the MHCPS. The expert panel that reviewed the definitions indicated the need for a spiritual dimension and this need was substantiated during the review of items. The MHCPS definition of spirituality (see Table 1) is not confined to a specific religious orientation (Vieten et al., 2013) and is aligned with Pargament's (2007) description of spiritually integrated therapy as a journey people take to discover and realize their higher order aspirations. The spirituality items are general in nature so that the items can be interpreted to reflect one or multiple sources of spirituality meaningful to the client. For example, a client's interpretation may reflect any of the four sources of spirituality outlined in Worthington's (2012) taxonomy of spirituality sources: (1) theistic spirituality, (2) nature spirituality, (3) human spirituality, and (4) transcendent spirituality.

A personal meaning factor was expected given that personal meaning is common to many definitions of hope across qualitative research (Larsen, Edey, & LeMay, 2007). Inclusion of a personal meaning dimension was not questioned by the panels that reviewed the definitions and items. Unexpectedly, no personal meaning items appeared on any of the six factors of the MHCPS. There are three plausible reasons for this. First, whereas personal meaning is a common facet found across qualitative research on the experience of hope, no known hope scale yields a separate personal meaning factor. This may reflect a difficulty in the measurement of personal meaning (Chamberlain & Zika, 1988; Francis & Hills, 2008; Morgan & Farsides, 2009). Second, therapy is an experience deeply and inextricably rooted in personal meaning. As such, it may be that measuring personal meaning as a dimension of hope is important but difficult to highlight against the contextual backdrop of therapy. Third, clients enter therapy seeking personal change. Thus, personal meaning is apt to be in flux during therapy, making it a 'moving target' to identify as a distinct factor during the therapeutic process. Further research on the relationship between personal meaning and hope during therapy may refine our understanding.

Implications for Counseling and Practice

A multidimensional scale, the MHCPS may prove a very practical means for locating client hope when it is difficult to find. As a clinical instrument both the total and the subscale scores have value. Many clients can become fixed on one hoped-for outcome (Larsen & Stege, 2010b). Some even define "success" in therapy as a single hoped-for outcome, such as repair to

an intimate relationship or access to any particular educational program. Should that single hope not materialize, the client may conclude that no hope exists, leading to what we might call "false despair" (Jevne, 2005). The MHCPS recognizes that client hope is complex, and that although a client may be currently focused on a particular hope, hope still exists across many aspects of life. Taking a multidimensional perspective holds the potential to educate counselors/psychotherapists and their clients to see hope as a more multifaceted experience. Whereas hope may be low on some subscales of the MHCPS, it is highly likely that higher hope will be apparent on other subscales, thereby offering evidence of the presence of hope. Therapists may choose to use the MHCPS to guide counseling conversation, discussing client responses to questions as a means of opening diverse conversations about client hope. For especially demoralized clients, the overall amount of hope measured, though indicative, may be less important than the ability to identify that some hope exists.

Information provided by the MHCPS about client hope may also be important for sustaining therapist hope, particularly when working with demoralized clients. Research indicates that counselor/psychotherapist hope can have a significant impact on client outcome (e.g., Coppock, Owen, Zagarskas, & Schmidt, 2010) and that counselor/psychotherapist hope appears to be highly dependent on internal in-session assessments of client progress (Larsen, Stege, & Flesaker, 2013). The MHCPS offers tangible evidence of client hope to the counselor even while working through deeply demoralizing circumstances with clients.

Limitations and Future Directions

Three identified limitations inform future research and clinical directions related to the MHCPS. First, the number of participants was less than expected, unfortunately a common occurrence given the complexity of conducting psychotherapeutic research. The expected number of participants was 500; however, only 211 were realized. Future research should include a confirmatory factor analysis on the MHCPS. Second, the MHCPS reflects a global western/northern-centric perspective on hope, reflective of the preponderance of hope research with a western focus at present. The literature reviewed and the participants selected for this research reflect this global western context. Future research should also investigate understandings and experiences of hope in therapy from other global perspectives such as the global south and Africa-centric understandings. Finally, future research and practice innovations should attend to developing evidence-based clinical uses of the MHCPS.

References

Antony, M., Beiling, P. J., Cox, B. J., Enns, W., & Swinson, R. P. (1998). Psychometric properties of the 42-item and 21-item version of the Depression Anxiety Stress Scales in clinical groups and a community sample. *Psychological Assessment, 10,* 176–181. http://dx.doi.org/10.1037/1040-3590.10.2.176

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy?* (pp. 23–55). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/11132-001

Bartholomew, T. T., Scheel, M. J., & Cole, B. P. (2015). Development and validation of the hope for change through counseling scale. *The Counseling Psychologist, 45,* 671–701. http://dx.doi.org/10.1177/0011000015589190

Chamberlain, K., & Zika, S. (1988). Measuring meaning in life: An examination of three scales. *Personality and Individual Differences, 9,* 589–596. http://dx.doi.org/10.1016/0191-8869(88)90157-2

Clark, L. A., & Watson, D. (1995). Constructing validity: Basic issues in objective scale development. *Psychological Assessment, 7,* 309–319. http://dx.doi.org/10.1037/1040-3590.7.3.309

Coppock, T. E., Owen, J. J., Zagarskas, E., & Schmidt, M. (2010). The relationship between therapist and client hope with therapy outcomes. *Psychotherapy Research, 20,* 619–626. http://dx.doi.org/10.1080/10503307.2010.497508

Cutcliffe, J. R. (2004). *The inspiration of hope in bereavement counselling*. London, UK: Jessica Kingsley.

DeVellis, R. F. (2003). *Scale development: Theory and applications* (2nd ed.). Thousand Oaks, CA: SAGE.

Devellis, R. F. (2012). *Scale development: Theory and applications* (3rd ed.). Thousand Oaks, CA: SAGE.

Dodeen, H. M. (2003). Effectiveness of valid mean substitution in treating missing data in attitude assessment. *Assessment & Evaluation in Higher Education, 28,* 505–513. http://dx.doi.org/10.1080/02602930301674

Downey, R. G., & King, C. (1998). Missing data in Likert ratings: A comparison of replacement methods. *The Journal of General Psychology, 125,* 175–191. http://dx.doi.org/10.1080/00221309809595542

Egeli, N. A., Brar, N., Larsen, D. J., & Yohani, S. (2014). Couples' experiences of hope when participating in the reflecting team process: A case study. *Contemporary Family Therapy, 36,* 93–107. http://dx.doi.org/10.1007/s10591-013-9280-4

Eliott, J. (2005). What have we done with hope?: A brief history. In J. Eliott (Ed.), *Interdisciplinary perspectives on hope* (pp. 3–45). New York, NY: Nova Science.

Fink, A. (2003). *How to ask survey questions* (2nd ed.). Thousand Oaks, CA: SAGE. http://dx.doi.org/10.4135/9781412984393

Francis, L. J., & Hills, P. R. (2008). The development of the Meaning in Life Index (MILI) and its relationship with personality and religious behaviours and beliefs among U.K. undergraduate students. *Mental Health, Religion & Culture, 11,* 221–220. http://dx.doi.org/10.1080/13674670701243758

Frank, J. D. (1961). *Persuasion and healing: A comparative study of psychotherapy*. Baltimore, MD: John Hopkins University Press.

Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: John Hopkins University Press.

Gorsuch, R. L. (1983). *Factor analysis* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.

Greenberg, L. (2004). Emotion-focused therapy. *Clinical Psychology & Psychotherapy, 11,* 3–16. http://dx.doi.org/10.1002/cpp.388

Herth, K. (1992). Abbreviated instrument to measure hope: Development and psychometric evaluation. *Journal of Advanced Nursing, 17,* 1251–1259. http://dx.doi.org/10.1111/j.1365-2648.1992.tb01843.x

Horvath, A. O., & Greenberg, L. S. (Eds.). (1994). *The working alliance: Theory, research, and practice*. New York, NY: Wiley.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.). (1999). *The heart and soul of change: What works in therapy?* Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/11132-000

Iaboni, K., & Larsen, D. (2019). *Systematic review of hope in counseling and psychotherapy qualitative research*. Manuscript submitted for publication.

Ilardi, S. S., & Craighead, W. E. (1994). The role of nonspecific factors in cognitive behavior therapy for depression. *Clinical Psychology: Science and Practice, 1,* 138–156. http://dx.doi.org/10.1111/j.1468-2850.1994.tb00016.x

Jevne, R. F. (2005). Hope: The simplicity and complexity. In J. Eliott (Ed.), *Interdisciplinary perspectives on hope* (pp. 259–289). Hauppauge, NY: Science Nova Publishers, Inc. http://dx.doi.org/10.1007/978-1-4613-9674-1

Juntunen, C. L., & Wettersten, K. B. (2006). Work hope: Development and initial validation of a measure. *Journal of Counseling Psychology, 53,* 94–106. http://dx.doi.org/10.1037/0022-0167.53.1.94

Larsen, D. J., Edey, W., & LeMay, L. (2007). Understanding the role of hope in counseling: Exploring the intentional uses of hope. *Counselling Psychology Quarterly, 20,* 401–416. http://dx.doi.org/10.1080/09515070701690036

Larsen, D. J., & Stege, R. (2010a). Hope-focused practices during early psychotherapy sessions: Part I: Implicit approaches. *Journal of Psychotherapy Integration, 10,* 271–292. http://dx.doi.org/10.1037/a0020820

Larsen, D. J., & Stege, R. (2010b). Hope-focused practices during early psychotherapy sessions: Part II: Explicit approaches. *Journal of Psychotherapy Integration, 10,* 293–311. http://dx.doi.org/10.1037/a0020821

Larsen, D. J., & Stege, R. (2012). Client accounts of hope in early counseling sessions: A qualitative study. *Journal of Counseling and Development, 90,* 45–54. http://dx.doi.org/10.1111/j.1556-6676.2012.00007.x

Larsen, D. J., Stege, R., Edey, W., & Ewasiw, J. (2014). Working with unrealistic or unshared hope in the counselling session. *British Journal of Guidance & Counselling, 42,* 271–283. http://dx.doi.org/10.1080/03069885.2014.895798

Larsen, D. J., Stege, R., & Flesaker, K. (2013). 'It's important for me not to let go of hope': Psychologists in-session experiences of hope. *Reflective Practice, 14,* 472–486. http://dx.doi.org/10.1080/14623943.2013.806301

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy, 33,* 335–343. http://dx.doi.org/10.1016/0005-7967(94)00075-U

Messick, S. (1989). Validity. In R. L. Linn (Ed.), *Educational measurement* (pp. 13–103). New York, NY: Macmillan.

Morgan, J., & Farsides, T. (2009). Measuring meaning in life. *Journal of Happiness Studies, 10,* 197–214. http://dx.doi.org/10.1007/s10902-007-9075-0

O'Hara, D. J., & O'Hara, J. F. (2012). Toward a grounded theory of therapist hope. *Counselling Psychology Review, 27,* 42–55.

Pargament, K. I. (2007). *Spiritually integrated psychotherapy: Understanding and addressing the sacred*. New York, NY: Guilford Press.

Redlich-Amirav, D., Larsen, D., & Armijo-Olivo, S. (2016). Evaluation of original hope scales: A critical review. In R. Watson (Ed.), *Spin cycle* (pp. 123–137). Oxford, UK: Inter-Disciplinary Press. http://dx.doi.org/10.1163/9781848883673_014

Robinson, C., & Rose, S. (2010). Predictive, construct, and convergent validity of general and domain-specific measures of hope for college student academic achievement. *Research in the Schools, 17,* 38–52.

Scheier, M. F., Carver, C. S., & Bridges, M. W. (1994). Distinguishing optimism from neuroticism (and trait anxiety, self-mastery, and self-esteem): A reevaluation of the Life Orientation Test. *Journal of Personality and Social Psychology, 67,* 1063–1078. http://dx.doi.org/10.1037/0022-3514.67.6.1063

Schrank, B., Brownell, T., Jakaite, Z., Larkin, C., Pesola, F., Riches, S., . . . Slade, M. (2016). Evaluation of a positive psychotherapy group intervention for people with psychosis: Pilot randomised controlled trial. *Epidemiology and Psychiatric Sciences, 25,* 235–246. http://dx.doi.org/10.1017/S2045796015000141

Schrank, B., Woppmann, A., Sibitz, I., & Lauber, C. (2011). Development and validation of an integrative scale to assess hope. *Health Expectations, 14,* 417–428. http://dx.doi.org/10.1111/j.1369-7625.2010.00645.x

Schwarzer, R., & Jerusalem, M. (1995). Generalized Self-Efficacy Scale. In M. Johnson, J. Weinman, & S. Wright (Eds.), *Measures in health psychology: A user's portfolio* (pp. 35–37). Windsor, UK: NFER-NELSON.

Scioli, A., Ricci, M., Nyugen, R., & Scioli, E. R. (2011). Hope: Its nature and measurement. *Psychology of Religion and Spirituality, 3,* 78–97. http://dx.doi.org/10.1037/a0020903

Snyder, C. R. (1994). *The psychology of hope: You can get there from here*. New York, NY: Free Press.

Snyder, C. R. (1995). Conceptualizing, measuring, and nurturing hope. *Journal of Counseling and Development, 73,* 355–360. http://dx.doi.org/10.1002/j.1556-6676.1995.tb01764.x

Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigmon, S. T., . . . Harney, P. (1991). The will and the ways: Development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology, 60,* 570–585. http://dx.doi.org/10.1037/0022-3514.60.4.570

Snyder, C. R., Michael, S. T., & Cheavens, J. (1999). Hope as a psychotherapeutic foundation for nonspecific factors, placebos, and expectancies. In M. A. Hubble, B. Duncan, & S. Miller (Eds.), *The heart and soul of change: What works in therapy?* (pp. 179–200). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/11132-005

Snyder, C. R., Sympson, S. C., Ybasco, F. C., Borders, T. F., Babyak, M. A., & Higgins, R. L. (1996). Development and validation of the State Hope Scale. *Journal of Personality and Social Psychology, 70,* 321–335. http://dx.doi.org/10.1037/0022-3514.70.2.321

Swift, J. K., & Greenberg, R. P. (2015). *Premature termination in psychotherapy: Strategies for engaging clients and improving outcomes*. Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/14469-000

te Riele, K. (2010). Philosophy of hope: Concepts and applications for working with marginalized youth. *Journal of Youth Studies, 13,* 35–46. http://dx.doi.org/10.1080/13676260903173496

Vieten, C., Scammell, S., Pilato, R., Ammondson, I., Pargament, K. I., & Lukoff, D. (2013). Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality, 5,* 129–144. http://dx.doi.org/10.1037/a0032699

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The research evidence for what works in psychotherapy* (2nd ed.). New York, NY: Routledge. http://dx.doi.org/10.4324/9780203582015

Ward, D. B., Griswold, K. R., Johnson, K., & Grahe, J. E. (2017). Beyond pathways and agency: Validating a four-factor theory of hope. *The American Journal of Family Therapy, 45,* 95–110. http://dx.doi.org/10.1080/01926187.2016.1277803

Ward, D. B., & Wampler, K. S. (2010). Moving up the continuum of hope: Developing a theory of hope and understanding its influence in couples therapy. *Journal of Marital and Family Therapy, 36,* 212–228. http://dx.doi.org/10.1111/j.1752-0606.2009.00173.x

Wickramasekera, I. (1985). A conditioned response model of placebo effect: Predictors from the model. In L. White, B. Tursky, & G. Schwartz (Eds.), *Placebos: Theory, research, and mechanisms* (pp. 255–287). New York, NY: Guilford Press.

Wilkins, W. (1979). Expectancies in therapy research: Discriminating among heterogeneous nonspecifics. *Journal of Consulting and Clinical Psychology, 47,* 837–845. http://dx.doi.org/10.1037/0022-006X.47.5.837

Wilkins, W. (1985). Placebo controls and concepts in chemotherapy and psychotherapy research. In L. White, B. Tursky, & G. Schwartz (Eds.), *Placebos: Theory, research, and mechanisms* (pp. 83–109). New York, NY: Guilford Press.

Worthington, E. L. (2012). Progress in physics and psychological science affects the psychology of religion and spirituality. In L. J. Miller (Ed.), *The Oxford handbook of psychology and spirituality* (pp. 47–62). New York, NY: Oxford University Press.

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment, 52,* 30–41. http://dx.doi.org/10.1207/s15327752jpa5201_2

Escala de esperanza multidimensional en la consejería y psicoterapia

La esperanza es una faceta fundacional en la psicoterapia y de las teorías de factores comunes en la psicoterapia. Las medidas principales de esperanza desarrolladas en la psicología no son diseñadas para medir la esperanza como se relaciona específicamentea la psicoterapia. Existe cada vez más evidencia que ambos contenido y procesos en relación con la esperanza tienen características únicas en este dominio complejo. La escala de esperanza multidimensional en la consejería y psicoterapia (MHCPS) fue desarrollada a través de un proceso multifase, incluyendo un repaso comprensivo de la literatura, encuestas empleando un grupo de expertos coincidentes, y validación de escala con 211 clientes en terapia en 7 ubicaciones canadienses, La MHCPS incluye 34 ítems a través de 6 subescalas: Orientación Futura, Espiritualidad, Cognitivo, Relación Terapeuta, Otras Relaciones, y Emocional. Las 6 subescalas y la escala completa poseían altas confiabilidades y buena validez convergente y divergente. Aspectos singulares de esta escala son la inclusión de una dimensión espiritual así como 2 dimensiones relacionales, reconociendo que la relación terapéutica es común, aunque no la única, experiencia relacional de esperanza para los clientes en terapia. La MHCPS ofrece una opción matizada y bien validada para las investigaciones psicoterapéuticas sobre la esperanza. Entre las muchas ventajas de la MHCPS es la habilidad de proveer información refinada de la compleja interrelación entre la esperanza del cliente y las relaciones del cliente (terapéutica y otras). Cuando se emplea en contextos clínicos, la MHCPS puede ser usada para identificar y abrir una gama de conversaciones clínicas acerca de donde y como la esperanza es actualmente experimentada por los clientes.

esperanza, escala, consejería, psicoterapia, multidimensional

在咨询和心理治疗量表中的多维度的希望

希望是心理治疗的一个根本的方面，也是心理治疗理论的共同因素。在心理学中的主要的希望量表并不是针对心理咨询中的希望而设计的。有更多的证据表明，在这个(咨询)复杂的领域中，关于希望的内容和过程都有其独特的特征。咨询与心理治疗中多维度希望量表(MHCPS)是通过多阶段过程发展出来，并且此过程包括全面的文献检索，利用各专家交叉平台的问卷，以及用在加拿大7个地点的211个咨询客户进行的量表验证。MHCPS包括了的34个题目并且分为以下六个分量表：未来导向性，灵性，认知的，治疗关系，其他关系，和情感的。这六个分量表以及整个量表都具有很高的信度,聚合效度和分歧效度。此量表特别之处在于加入了灵性维度以及两个关系性维度，并认识到咨询关系虽然不是唯一的关系性体验，但也是一个在治疗中一个常见的并与希望有关的关系性体验。MHCPS为以希望为主题的心理治疗方面的研究提供了一个细微以及很好地被验证过的选项。在众多的MHCPS的资产中，有一个能力可以为存在于“客户希望”与“客户关系(咨询的和其他的)”之间的复杂的相互关系提供精细的信息。当被运用于临床环境中，MHCPS可以针对“客户正在哪里体会希望以及怎样体会希望”来识别并且开辟一些列临床对话。

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